Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that following the design of the patients. (See instructions.) Except for nursing homes, the findings stated above are discovered to the patients.

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whather or not a plan of correction is provided. For nursing homes, the shove findings and plans of correction are disclosable 14 program participation.

and interview, the facility falled to notify the physician in a timely manner of a Registered

includes the Registered Dietitian

flushes of 50 ml four times a day. Medical record review of a Registered Dietician (RD) note dated September 25, 2013, revealed wt (weight) loss from 117.3 lbs to 102.6 lbs 9/22/13. Wound on sacrum. Recommend to Increase TF (tube fedding) rate to 65ml/hr (65 milliliters per hour) continuous. This would increase calories to 1872/24 hrs. Water flush 100ml q (every) 4 hrs. Goal = stop wt loss."

Medical record review revealed no documentation the physician had been notified of the recommendation to increase the Glucerna 1.2 to 65 ml per hour until October 17, 2013.

Medical record review of a Physician's Progress Note dated October 17, 2013, revealed "wt. (weight) loss noted but edema has improved dramatically...plan 1) (increase) TF (tube feeding) and monitor resident..."

recommendations timely. All licensed nurses will be reeducated by the Director of Nursing on the importance of following up on recommendation immediately by November 30, 2013.

The Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor will audit all resident's records that are seen by the Registered Dietitian weekly for 4 weeks then twice monthly for 3 months. Audits will be presented monthly in the Quality Assurance Process Improvement meeting November 30, 2013.

	_ CENT	ERS FOR MEDICARE	& MEDICAID SERVICES	423	3-245-8957	T-198	P0004/	0026 F-45	1
	I A IVA CINICI	M CCDEFERRENCES	CAL DROWNER SERVICES				. Ur	TRY ALPEDIN	
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION		CIAIR I	<u>IO. 0938-03</u>	8
ĺ	İ		The state of the s	A. BUILE	ING		(X3) C	ATE SURVEY OMPLETED	
ļ			445481			<u></u>	"	AMLEG158	
ı	NAME OF	PROVIDER OR SUPPLIER	4-5401	B. WING		-			
Į				1	STREET ADDRESS, CITY, STA	TE. ZIP CODE		0/23/2013	
I	ASBUR	Y PLACE AT KINGSPO	RT	- 1	IND NETHERLAND LANE				
ľ	(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	<u></u>	KINGSPORT, TN 37660				
l	PREFIX TAG			ID PREFIX	PROVIDER'S PLAN	NOF CORRECT	ION		
	IAG	REGODATORY OR LS	C IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE CROSS-REFERENCED	ころいていへい ひひろこ		(X5) COMPLETIO	N
	·				DEFIC	ENCY)	JPRIATE	.DATE	
	F 157	Continued From pag	• 0				 ,		
		Observation as O-t-	0	F 15	57	•		1	ł
		revealed the resident	ber 21, 2013, at 3:32 p.m., lying on the bed receiving	ł	1			ł	- 1
	- 1	Glucerna 1.2 at 65ml	her bour	1				}	[
	į	•		1	}			i	- [
	- 1	Interview on October	22, 2013, at 2:45 p.m., with					1	ł
					1.			1	1
	1.	AMAR' COMMUNICIED LIGHT	つりかくさいらい いいへい いっしゅーバビー・ビース	: [1]	1
		mag reconsidencesion i	N IDRIAGRA the Chieses I	İ				}	Ĺ
	F 221	65ml per hour until Oc 483.13(a) RIGHT TO	2008F17, 2013. PE EREE ERO:	[ļ			[1
	SS=D I	PHYSICAL RESTRAI	NTS	F 221	· 1			ļ	
	1	·	•		Restraint assessme	nts have h	opn —	11/30/2013	
	7	The resident has the r	ight to be free from any	ļ	completed for resid	ents #132	#115	41/20/2013	L
	1 10	wiyolodi testraling imn	DSOM for purposes at	ŀ	and #49. Care plans	for these	π112,	1	l
	Į u	newhille of coursuler	ICA Shri not rosnicost to	ļ	residents have been	o to these			l
	"	reat the resident's me	dical symptoms.]	accordingly,	nbaátéa	ļ		
			•	[accordingly,]		1
	_ T.	his REQUIREMENT	is not met as evidenced		Bu Navanal aa		j		İ
	N	<i>3</i> •			By November 30, 20	13, the fac	ility		
	E	sased on medical reco	ard review, facility policy		wiii nave completed	an audit A	in all	į	Į
	1 10	men, observation an	A INTORGONAL BLACK - 112.		peds by Assistant Di	rector of N	ureina l		
	(#	138. #112 and #40\	of restraints for three of twenty-three residents		and/or Registered N	urse Suner	Wisor	Ī	
	re	Viewed.	n twenty-three residents		Residents with two s	ide raile in	أعمدام	i	
	Ĭ				that would be consid	leted a roc	trains	J	
	Th	ne findings included:	J		will be assessed usin	a the costs	uaint	1	
٠	, p-	seidant #40a		j	assessment form.	2 me 162(1)	¥IDC		
	00	esident #138 was adm	litted to the facility on		TOTAL		1	ļ	
	As	ctober 15, 2013, with a piration Pneumonia,	Maynoses including	ļ	All nurcion water and				
	Rh	eumatoid Arthritis, an	ne let crisiniation,	,	All nursing staff will I	oe educate	⊵d to	ļ	
			F		the use of side rails a	s positioni	ng	j	
	Me	dical record review of	f the Side Rail		and safety devices an	d when th	ey	- 1	
) As:	sessment dated Octo	her 15 2019 several	J	are considered restra	ints.	- }		
	1110	Leginetit AS60 (16 D6	d rails to assist in turning		Documentation requi	rements w	/ill be	f	
	1 4116	d repositioning.	- }	-	included in this educa	tion. This		- 1	
					education will be com	inleted hy	ŀ		
			i			winder try			

to exit the bed, and confirmed the one-half side rails raised in the mid-point of the bed, prevented the resident from exiting the bed in a normal manner, and confirmed the resident had not been assessed for the use of a restraint.

Resident #112 was admitted to the facility on October 9, 2013, with diagnoses including Diarrhea, Urinary Tract Infection, and Dementia.

Medical record review of a physician's order dated October 9, 2013, revealed "...Side rails up times 2 to aide in turning and repositioning..."

Medical record review of the Side Rail Assessment dated October 9, 2013, revealed ...Medical symptom requiring usage of bed rails: weakness, confusion ...(up) x 2 to aid (turning and repositioning)..."

Medical record review of the Physical Therapist Progress Note dated October 16, 2013, revealed "...able to safely complete all functional transfers requiring minimal assistance...able to safely transition from sit stand requiring minimal

Director of Nursing and/or Registered Nurse Supervisor will also ensure that the care plan reflects the reason for use of side rails and if an assessment is completed for the use of a restraint. Results of the audits will be

presented monthly in the Quality Assurance Process Improvement meeting.

<u> </u>	12-18-'13 17:01 FF	ROM-Asbury	423-	-245-8957			1026 F~451
AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) FROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	IPLE CONSTRUCTION NG	<u> </u>	(X3) DA). 0938-039 TE SURVEY MPLETED
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ł	OF PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STA	ATE ZIPCODE	10	/23/2013
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F 22	Continued From pag assistance"	re 4	F 22				
	TICACOTED DIG 168(DEUI	ber 22, 2013, at 2:45 p.m., I lying on the bed with half led position raised bilaterally.					
	TOWNSTONE TOOM, WI	22, 2013 at 1:20 p.m., in the the Assistant Director of assessment had been a of the siderails as a					
	r 🋂 ZV (3. Willi diagnoss	mitted to the facility on May es including Fractured Hip, ral Vascular Disease, and	į		٠		
	Joes the resident in	of the Side Rail gust 15, 2013, revealed se the bed rails to assist in ngyesSR (side rails)				}	
1	Medical record review of assessment for the side completed.	revealed no restraint e rails had been					
	revealed the tesidebly M	r 23, 2013, at 8:00 a.m., ing on the bed, with haif position raised bilaterally.					
	nacama prancti Mill Fice	2, 2013, at 3:00 p.m. at the ensed Practical Nurse #1, was able to self transfer elchair.				ļ	

CENTERSTOR	MEDICAR	ROM-Asbury & Medicaid Services	423-	-245-8957	T-198	P0007/	[/] 0026 F-451
STATEMENT OF DEFI	じょうしょう	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A BUILDIN	IPLE CONSTRUCTION	······································	(X3) (NO. 0938-036 DATE SURVEY COMPLETED
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I PREFIX! (EA)	711 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	KCTION SHOL O THE APPRI	(III D D D ==	COMPLETION DATE
complete restrainted 483.20(gray ACCUR) The assert residented A register each assert participated assessment that portion Under Mewillfully and false state subject to \$1,000 for willfully and to certify and to certify and the state of the certify and the state of the certify and the state of the certify and the state of the certify and the certify and the state of the certify and the certify and the certify and the certify and the certification of the certification o	c) - (j) ASSE: ACY/COORT essment muse status. red nurse muse sesment with ion of health red nurse must sign n of the asset dicare and Mark to a civil mone; each assess d knowingly material and materia	e of the side rails as a SSMENT DINATION/CERTIFIED at accurately reflect the ust conduct or coordinate in the appropriate professionals. ust sign and certify that the eted. completes a portion of the	F 278	DEFICIE	en updated of the reside intervent we a dental sed by Director stered Number 30, 2 placed in the red staff mber 30, 2 places a placed in the red staff mber 30, 2 places a placed in the rector of stered Number all new ssessment	d to ident's ntion. ral rector of urse 2013. the 2013 ctor of	11/30/2013

assessment.

penalty of not more than \$5,000 for each

Clinical disagreement does not constitute a

This REQUIREMENT is not met as evidenced

Based on medical record review, observation, and interview, the facility failed to ensure an

material and false statement.

the next 4 weeks, and then 5

admissions each month. Audit

results will be reported to the

Quality Assurance Process

Improvement committee.

TATATEMENT OF DEPOCHCIES AND PLAN OF CORRECTION PART PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT A SULIDING A SURIDING			A MEDICAID SERVICES			2042	THE CHANGE		
ASBURY PLACE AT KINGSPORT O(A) ID O(A) ID (EACH DESIGNATION OF DEFICIENCIES (EACH DEFICIENCY) FRETIX TAG CONTINUED FROM THE REPORT (EACH DEFICIENCIES (EACH DEFICIENCY) FROM TAG FOR THE REPORT (EACH DEFICIENCY) FROM TAG FROM THE REPORT (EACH DEFICIENCY) FROM TAG FROM THE REPORT (EACH DEFICIENCY) FROM TAG FROM THE REPORT (EACH DEFICIENCY) FROM TAG FROM THE REPORT (EACH DEFICIENCY) FROM TAG FROM THE REPORT (EACH DEFICIENCY) FROM THE RESOLUTION THE REPORT (EACH DEFICIENCY) FROM THE RESOLUTION THE REPORT (EACH DEFICIENCY) FROM THE RESOLUTION THE REPORT (EACH DEFICIENCY) FROM THE RESOLUTION THE RESOLUTION THE CONTRIBUTION THE CONTRIBUTION THE CONTRIBUTION THE		STATEME AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	ALTE COMPLETION	(X3) D	ATE SUBVEY	<u>91</u>
ASBURY PLACE AT KINGSPORT O(A) ID PREFIX TAG SUMMARY STATEMENT OF DEPOSENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL TAG FEGULATORY OF LISC IDENTIFYING INFORMATION) F 278 Continued From page 6 accurate assessment of dental status for one resident (#6) of twenty-fines residents reviewed. The findings included: Resident #6 was admitted to the facility on August 30, 2013, with diagnoses including Aspiration Preumonia, Dysphagia, Anemia, Hypertension, and Status Post Colostomy. Medical record review of the admission Minimum Data Set (MDS) dated September 12, 2013, revealed the resident to do ental issues were identified. Observation on October 21, 2013, at 3:32 p.m., revealed the resident tying on the bed, with some missing upper teeth, and stated needed a root canal. Observation and interview on October 22, 2013, at 3:00 p.m., with the DioN described the residents teeth as appearing to have decay with some missing teeth. Interview, on October 22, 2013, at 3:05 p.m., with the DON, in the DON's office onfirmed the MDS dated September 12, 2013, do not reflect the resident's likely cavilies and confirmed the Resident-Data Collection form dated August 30, 2013, was not accurate as the resident had teeth. F 279 482.20(4), 483.20(4) 105.EVELOP F 279 482.20(4), 483.20(4) 105.EVELOP F 279 482.20(7), 483.20(4) 483.20(6)	ı		·	445481	B. WNO_				
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accurate assessment of dental status for one resident (#8) of twenty-three residents reviewed. The findings included: Resident #8 was admitted to the facility on August 30, 2013, with diagnoses including Aspiration Pneumonia, Dysphagia, Anemia, Hypertension, and Status Post Colostomy. Medical record review of the Resident-Data Collection form dated August 30, 2013, revealed the resident did not have any teeth or dentures. Medical record review of the admission Minimum Data Set (MDS) dated September 12, 2013, revealed no dental issues were identified. Observation on October 21, 2013, at 3:32 p.m., revealed the resident lying on the bed, with some missing upper teeth, and stated needed a root canal. Observation and interview on October 22, 2013, at 3:00 p.m., with the Director of Nursing (DON) revealed the resident lying on the bed, and the DON described the resident's teeth as appearing to have decay with some missing teeth. Interview on October 22, 2013, at 3:05 p.m., with the DON, in the DON's office confirmed the MDS dated September 12, 2013, did not reflect the resident's little varieties of the Resident-Data Collection form dated August 30, 2013, was not accurate as the resident had teeth. F 279 483.20(d), 483.20(k)(1) DeVELOP		PRÉFIX	: (EACH DEFICIENCY	MUST BE PRECEDEN BY BUT	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROT	D DE		N
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		SS≃D	COMPREHENSIVE C	ARE PLANS					

CENITS	COS COD MEDIONOS	S 14FDIO 11 American	423-	7-198 T-198	P0009/0	026 F-451
STATEMEN	NT OF DEFICIENCIES	& MEDICAID SERVICES				D. 0938-039
AND FLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE GONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
<u></u>		445481	B. WING_		ĺ	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	10	/23/2013
ASBUR'	Y PLACE AT KINGSPO)RT	ľ	100 NETHERLAND LANE		
				KINGSPORT, TN 37660		
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F 279	Continued From pag	je 7	F 279	F 279		11/20/2012
-	A facility must use th	ie results of the assessment	1 219	The care plan for resident #6		11/30/2013
	i to develop, review a	nd revise the residents	ĺ	reflects issues and risks of we	лоw	
	comprehensive plan	of care.		loss donressina and risks of We	egnt]
	The facility must dev	elop a comprehensive care		loss, depression and anxiety.		<u> </u>
	plan for each resider	it that includes measurable		Appropriate Interventions are	also in	
•	objectives and timeta	ables to meet a resident's		place for this resident.		
	medical, nursing, and	f mental and psychosocial		But and		ł
- 1	needs that are identif assessment.	isd in the comprehensive	i	By November 30, 2013 all lice	nsed	
j	dogesofficit,			staff will be re-educated by th	ie	
-	The care plan must d	escribe the services that are		Director of Nursing on updating	ng care	
į į	to be turnished to atta	in or maintain the resident's l	ļ	plans and following up on		:
1.	highest practicable pl psychosocial well-bei	nysical, mental, and		recommendations from other	•	İ
[]	\$483,25; and anv sen	Vices that would otherwise		practitioners/professionals.	·	İ
[1	oe required under §48	33.25 but are not provided		By December 31, 2013, all cur	rent	j
(que to the residents ϵ	EXECCISE of rights under		resident care plans will have b	een	
1	inder §483.10(b)(4).	right to refuse treatment	- 1	reviewed by the Assistant Dire	ctor	
	G (-) <u>/</u> //	ļ		of Nursing to ensure all care is	SHAC	
	This productions are the		-	are included on the care plan.		
	inis REQUIREMENT :	is not met as evidenced	[į	
· [1	Based on medical rec	ord review, observation,		Director of Nursing, Assistant	. [j
Į a	ing interview, the facil	ity failed to develop a core		Director of Nursing and/or		ĺ
Į p	ian to address weigh	1088, depression and		Registered Nurse Supervisor w	in [
l a	mxiety for one (#6) of Sviewed.	twenty-three residents		perform weekly review of weig	ihte	ŀ
"	ovialiou.		ļ	Any change in nutritional statu	e will	
	he findings included:	ľ	[be updated in the resident's ca	ro	
	national III	45-31-11 0 W-		plan to reflect any change,]	Í
3	iesideni #0 Was 20Mii O. 2013. with disance	tted to the facility on August es including Aspiration	1	· · · · · · · · · · · · · · · · · · ·	.	
ě	neumonia. Dvsphania	a, Anemia, Hypertension		Effective January 1, 2014, Direc	******	
a	nd Status Post Colos	lomy,		Nursing, Assistant Director of	TO JOH] .
ľ	•			Nursing and/or Registered Nurs	_	
Į M	lectical record review	of a Registered Dietician	1	Supervisor will perform audits	5 e	
[15]	vor note gateg sebte	mber 25, 2013, revealed		~~~~, 413/11 MIN DGHOLM SHUBE 1	カロン し	1

T-198 P0010/0026 F-451

	CEN	TERS FOR MEDICARE	& MEDICAID SERVICES	724		'0010/0026 E	
	STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIERICALA	(X2) MUL	TIPLE CONSTRUCTION .	<u> MB NO, 093</u>	8-039
		W. D. BOURED HOM	IDENTIFICATION NUMBER:	A. BUILD	NG	(X3) DATE SUR COMPLETE	VEY ID
i			445481	B. WING			
	NAME	OF PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	10/23/20	13
Ì	ASBU	RY PLACE AT KINGSPO)rt ·	-	100 NETHERLAND LANE KINGSPORT, TN 37860		
ı	(X4) II PREFI	SUMMARY STA	YEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	į įD	PROVIDER'S PLAN OF CORRECTIO	N	
	TAG	REGULATORY OR LS	BC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	9 N P	X5) 'LETION ATE
	F 27	9 Continued From pag	ne 8	F 27	g charts per hall per week for 4 w	rooks.	<u> </u>
		"wt (weight) loss from	m 117.3 lbs to 102.6 lbs	"2"	to ensure care plans reflect all	care	.
		9/22/13"	•		issues for the resident.	ł	
		Medical record revie	w revealed the resident		Audit findings will be reported	each	- 1
		weighed 95 lbs. on C	October 15, 2013.		week in Quality of Life/Quality	of	
		Medical record review	w of a psychiatric note dated		Care meeting to the interdiscipi Team and to the Quality Assura	inary	Ì
		seen for mood and b	revealed the resident was chaviors, anxiety, depressive		Process Improvement monthly.	nce	j
		signs and symptoms	With recommendations for]			l
		needed Xanax (antiat	t) and to increase the as				
		Medical record review	of the Care Plan dated				
		the resident's weight i	ealed no documentation of oss, depression, anxiety, or			İ	j
		the possible side effect and antianxiety medic	Cl8 Of the antidenrassant				
		Interview on October 2	23, 2013, at 9:55 a.m., with				
	Ť	the Director of Nursing office confirmed a Car	I (DON), in the DON's				
		developed to address	the resident's weight loss.				
		Interview on October 2	23, 2013, at 12:50 p.m.,				- 1
		room, commued a car	rsing, in the conference		•	i i	
		developed to address	the resident's denression				
		anxiety, or the possible antidepressant and an	side effects of the fianxiety medications		F 280		İ
	F 280	.483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		11/30/2	2013
	SS=D	FARTIOIPATE PLANN	ING CARE-REVISE CP		for resident #138 has now been	arm	
		The resident has the ri	ght, unless adjudged	:	placed on care plan. The care pla	_m .	1.
	ŀ	incompetent or otherwi incapacitated under the	ise found to be		for resident #62 now reflects the	use	
	ŀ	participate in planning of	care and treatment or		of the geri-chair for positioning.		
		changes in care and tre	earment,		The state of the s		ŀ
-		The second secon			l .		

	STATEMEN	NT OF DEFICIENCIES	ON PROPERTY OF TAKEN	<u>.</u>		OMP	MO COST
	AND PLAN	OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	[(X(3)	NO. 0938-039 DATE SURVEY COMPLETED
ļ			445481	B. WING	•		•
		PROVIDER OR SUPPLIER Y PLACE AT KINGSPO	RT		STREET ADDRESS, CITY, STATE, ZIP COD 100 NETHERLAND LANE	<u> </u> E	10/23/2013
ľ	(X4) tD	SUMMARY STAT	EMENT OF DEFICIENCIES		KINGSPORT, TN 37660		
	PRÉFIX TAG	I (EACH DEFICIENCY)	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	Alun ne	COMPLETION DATE
	Ti bi i a pi a sa sa sa Ti Rica Ai De qui Me	comprehensive assessinterdisciplinary team, physician, a registerer for the resident, and of disciplines as determined the resident, the resident, the resident, the resident, the resident representative; and revised by a team each assessment. This REQUIREMENT by: Based on observation, and interview the facility and for a positioning disafety alarm for one (ampled residents. The findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident #62 was admined the findings included: The sident for a position of the sident in a sident findings included the resident in a sident findings included the resident in a sident findings in a sident	re plan must be developed a completion of the sement; prepared by an that includes the attending d nurse with responsibility other appropriate staff in ned by the resident's needs, cticable, the participation of ent's family or the resident's and periodically reviewed of qualified persons after is not met as evidenced medical record review, y failed to revise a care evice for one (#62), and for #138) of twenty-three tited to the facility on July is including Anemia, analysis Agitans, and 122, 2013, at 2:00 p.m., the resident's room sitting a reclined position.	F 28		owing upother by irrent been bing, ing, or to uded ector of irse s on 2 weeks I care i each of plinary rance	
	as	sessed the resident o	n July 18, 2013, and the days an assistive device		•		

	CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES	47	10- 24 0-8501	T-198 F	0012/	0026 F-4!	51
	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA). <u>09</u> 38-03	
ĺ	AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION NO.	_	(X3) DA	TE SURVEY MPLETED	<u>ia I</u>
l			4454B1	B. WNG	•				
ŀ	NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, S		10	/23/2013	
l	ASBUR	Y PLACE AT KINGSPO	RT		100 NETHERLAND LANE			-	
ľ	(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES		KINGSPORT, TN 3766		٠		
	PREFIX TAG	(CAUS DEFICIENCY	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREFI) TAG	CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPR ICIENCY)		COMPLETIO DATE	N
	F 280	Continued From pag for positioning the re-		F 28	80				
		Review of the resider dated May 6, 2013, a concerning the use o positioning.	nt's current Care Plan Report evealed no documentation f the geri-chair for						
	c	the DON's office on C a.m., confirmed the carevised to include the device. Resident #138 was ac October 15, 2013, with Aspiration Pneumonia Rheumatoid Arthrilis, a	geri-chair as a positioning Imitted to the facility on In diagnoses including Atrial Fibrillation, and Diabetes Mellitus.						
	V	vas at high risk for fall							
	e a ir ti	ivestigation revealed the personal safety ala	ealed the resident Out injury, in the bathroom I review of the fall the resident had removed Im (PSA) at the time of the						
	p.	svealed the resident si	r 22, 2013, at 1:05 p.m., eated in a wheelchair, at nch, with a personal safety						
	O ris	fedical record review of otober 15, 2013, reve sk for falls, however, to ocumentation of the ne	of the Care Plan dated aled the resident was at here was no sed for the PSA.	,					

1	CEIVI	ENS FOR WEDICARE	& MEDICAID SERVICES		•	يروب و	יי טבעצאאב	L
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	Lra construction	(X8) DA	D. 0938-039 TE SURVEY MPLETED	11	
ŀ	A1502# C	- Manual Control	445481	B, WING_			-	
		OF PROVIDER OR SUPPLIER RY PLACE AT KINGSPO	PRT	1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660	<u> </u>	<u>//23/2013</u>	_
	(X4) ID PREFIX TAG	() (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DC .	COMPLETION DAYE	_
	F 28	Interview on October	r 22. 2013. at 1:40 n m with	F 280				
	F 281 SS=D	conference room, confer	of Nursing, in the infirmed the Care Plan had notude the need for the	F 281	F 281 A physician order has been obtator for the Foley catheter, size and frequency of changes for residents.		11/30/2013	
		Based on medical reand interview, the faci physician's orders for frequency of changes one (#14), of twenty-the findings included: Resident #14 was re-a September 25, 2013, vanishing Urinary Rechronic Kidney Disease Medical record review admitted with a #16 (si Continued review reve for the size, care, and the urinary catheter.	the size, care and for a urinary catheter for a urinary catheter for a urinary catheter for a urinary catheter for a urinary catheter. The size, care and for a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter. The size are a urinary catheter for a urinary catheter. The size are a urinary catheter for a urinary catheter. The size are a urinary catheter for a urinary catheter. The size are a urinary catheter for a urinary catheter for a urinary catheter.		All medical records for residents with Foley catheters will be audit by the Director of Nursing, Assis Director of Nursing and/or Registered Nurse Supervisor to ensure that the size, care and frequency of change is ordered the physician. This review will be completed by November 30, 201 All licensed staff will be reeducated on the need for documentation of reason for Foley catheter, size, cand how often catheter is to be changed by November 30, 2014 I Director of Nursing.	by e l3. ted of are, by		
		revealed the resident iv	er 23, 2013, at 9:00 a.m., ring on the bed. Continued ne resident had a #16/30cc ellow urine noted.		he assessed by Assistant Director Nursing or Registered Nurse Supervisor for use of Foley			

STATEMENT OF DEPOSICIONS (XI) PROVIDENCULATION NUMBER AND PLAN OF CORRECTIONS (XI) PROVIDENCULATION NUMBER 445461 A SULDING A SULDING (XI) PROVIDENCULATION NUMBER A SULDING A SULDING (XI) PROVIDENCULATION NUMBER A SULDING (XI) PROVIDENCULATION NUMBER A SULDING (XI) PROVIDENCULATION OF COMPLETO A SULDING (XI) PROVIDENCULATION OF COMPLETO A SULDING (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCULATION OF COMPLETO (XI) PROVIDENCE OF COMPL	CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			. 0077,0070 [40
ASBURY PLACE AT KINGSPORT SUMMARY SATEMBLAND LANE (REGULATORY OR ISC IDENTIFYING INFORMATION) F 281 Continued From page 12 Interview with the Director of Nursing (DON) in the DON's office on October 23, 2013, at 9:30 a.m., confirmed no physician orders were obtained as to catheter care, size, or schedule of catheter names and care. F 309 SS=D This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the physician's order regarding the pharmacy consultants' recommendation for one resident (#45) of twenty-three residents reviewed. The findings included: Resident 45 was admitted to the facility on July 6, 2012, with diagnoses including Hypertonsion, Hyperilpidemia, Anemia, Mental Disorder, Depressive Disorder, Anemia, Renal Call Carcinoma, Arthrits, Diabetes Melitius, and Delirum. Medical record review of the Medication Regimen Medical record review of the Me	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ILLE COUSTRUCTION	(X3) DATE SURVEY
ASBURY PLACE AT KINGSPORT Continued From page 12 Deficiency must be precised by Full recommendation of the DON's office on October 23, 2013, at 9:30 Deficiency must be precised by Full recommendation of the DON's office on October 23, 2013, at 9:30 Deficiency must be precised by Full recommendation of the DON's office on October 23, 2013, at 9:30 Deficiency must be precised by Full recommendation of the DON's office on October 23, 2013, at 9:30 Deficiency must be provided by the Carles of the Approximate of the Chart will be audited for earliester changes and care, size, or schedule of catheter, size, care and frequency of changes. The results of the audits will be reported by Director of Nursing to the Quality Assurance Process Improvement committee.	<u> </u>	·	445481	B. WING_		detions
PROPERLY STATEMENT OF DEFICIENCY AND THE PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF THE PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF THE PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF THE PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG SHAPE OF CONNECTION PROPERTY TAG			PRT		100 NETHERLAND LANE	10/23/2013
Interview with the Director of Nursing (DON) in the DON's office on October 23, 2013, at 9:30 a.m., confirmed no physician orders were obtained as to catheter care, size, or schedule of catheter changes and care. F 309 SS=D Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and paychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the physician's order regarding the pharmacy consultant's recommendation for one resident (#45) of twenty-three residents reviewed. The findings included: Resident #45 was admitted to the facility on July 6, 2012, with diagnoses including Hypertension, Hyperfibldemia, Amenia, Mental Disorder, Depressive Disorder, Anxiety State, Allered Mental State, Insomnia, Renal Cell Carcinoma, Arthritis, Diabetes Melitus, and Delirlum. Medical record review of the Medication Regimen Review dated August 30, 2013, revealed a Within 7 days of the pharmacist's	PREFIX	J (EACH DEFICIENCY	MIRTER SEFECTOR BY CITE	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	
Review dated August 30, 2013, revealed a Within 7 days of the pharmacist's	F 309 SS=D	Interview with the Dithe DON's office on a.m., confirmed no pobtained as to cather catheter changes and 483.25 PROVIDE CATHIGHEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WELL BEILDEST WITH THE REQUIREMENT by: Based on medical receptation of care. This REQUIREMENT by: Based on medical receptation of the pharmac recommendation for other eresidents review The findings included: Resident #45 was adm 3, 2012, with diagnose Hyperlipidemia, AnemilDepressive Disorder, Amental State, Insomnia	rector of Nursing (DON) in October 23, 2013, at 9:30 hysician orders were ter care, size, or schedule of d care. RE/SERVICES FOR ING acceive and the facility must by care and services to attain st practicable physical, ocial well-being, in comprehensive assessment is not met as evidenced cord review and interview, low the physician's order cy consultant's ne resident (#45) of twenty-ed. hitted to the facility on July s including Hypertension, a, Mental Disorder, Anxiety State, Altered a, Renal Celi Carcinoma.		Catheters. If a catheter is prese the chart will be audited for evidence of a physician order fo catheter, size, care and frequen changes. The results of the audits will be reported by Director of Nursing the Quality Assurance Process Improvement committee. F 309 The physician has addressed the pharmacy recommendation for resident #45. All charts will be audited by November 30, 2013 to make sure pharmacy recommendations hav been followed up on by the Direct of Nursing. The Assistant Director of nursing Registered Nurse Supervisor will re-educated by Pharmacy Consultant about following up on pharmacy recommendations by	e all rector
	F	Review dated August 3	30. 2013, revealed a		Within 7 days of the pharmacist's visit and receipt of	

T-198 P0015/0026 F-451

CENT	TERS FOR MEDICARI	& MEDICAID SERVICES	40			1026 F-451
ISTATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NO	.0938-0391
		IDENTIFICATION NUMBER	A. BUILD	ing	COM	E SURVEY IPLETED
NAME C	OF PROVIDER OR SUPPLIER	445481	B. WING		40/	<u>23/</u> 2013
i	RY PLACE AT KINGSPO	ort	1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE	. 102	<u> 201</u> 2013
(X4) ID		TEMENT OF DEFICIENCIES		KINGSPORT, TN 37660	`	:
PRÉFI) TAG	L I CEAUH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	ES been	(X5) COMPLETION DATE
F 309	"change Risperidone tab (tablet) po (by m 0.25mg one half tab (gradual dose reducing Further review of the Review dated Augus written response from "ask Mental Health." Medical record review documentation Mental related to the GDR. Medical record review revealed, Resident #4 Risperidone 0.25mg of table 1.5 mg of the table 1.5 mg of table 1.5 mg o	e 0.25mg (milligrams) 1 (one) outh) 9 pm to Risperidone po 9 pm as a trial GDR ion)." Medication Regimen t 30, 2013, revealed a signed of the attending physician.		Nursing and/or Registered Nursing and/or Registered Nursing and/or Registered Nursing and/or Registered Nursing and/or Registered Nursing and/or Registered Nursing and/or Registered Nursing the file of recommendations to the Quality of Care meeting for second review to ensure that a recommendations have been addressed by the respective physician. Any recommendations that lack response, will be managed with hours of this second review. Completion date November 30, 2013.	rse ity of or a ill k a nin 48	
SS=D	room, confirmed the fathe physician's orders seen Resident #45 regreduction of Risperidor 483.25(i) MAINTAIN NUNLESS UNAVOIDABBASED on a resident's casessment, the facility resident - (1) Maintains acceptability status, such as body wunless the resident's oldemonstrates that this	citu p.m., in the conference icility had failed to follow and Mental Health had not larding the gradual dose ne. UTRITION STATUS LE comprehensive must ensure that a le parameters of nutritional eight and protein levels, inical condition	F 325	The Director of Nursing, Assistar Director of Nursing and/or Registered Nurse Supervisor will complete audits on 10% of medi records with pharmacy recommendations each month fronths. Results will be presented by the Director of Nursing at the Quality Assurance Process Improvement	ical or 3	

CENT	ERS FOR MEDICARE	E & MEDICAID SERVICES	443	T-198 F	°0016/	0026 F-451
STATEM	ENTERS FOR MEDICARE & MEDICAID SERVICES EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI T	PLE CONSTRUCTION	MB NO	D. 0938-039
AND POA	N OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	G	(X3) DA	TE SURVEY MPLETED
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NAME C	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	/23/2013
ASBU	RY PLACE AT KINGSPO	DRT	ł	100 NETHERLAND LANE		
(X4) ID	CI IMPARA CAL	P7402100 Au		KINGSPORT, TN 37680		
PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Must be preceded by Full BC Identifying Information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DI:	COMPLETION DATE
F 328	Continued From pag	ge 14 .	F 326	F 325	-	
			, 42.	The Registered Dietitian has be consulted for resident #112 and		11/30/2013
	Inis REQUIREMEN by:	T is not met as evidenced		recommendations have been	1] .
	Based on medical re	ecord review, observation,	1	reviewed by the physician and		
	and interview, the fac	cility failed to ensure an	}	implemented. This resident's		
	Dietician for one (#11	npleted by a Registered 12), and failed to ensure tube		weight has stabilized.		
	i teedings were admin	istered as ordered for one — i		A now 6	İ	_
	(#6) of twenty-three	residents feviewed.		A new form used to record all to	ıbe	•
	The findings included	:		feeding amounts and flush amounts by shift has been designed and	unts	- 1
] Resident #112 was a	dmitted to the facility on	ı	placed on the front of the		
;	October 9, 2013, with	diagnoses including		Medication Administration Reco	rd	. [
i	Diarrhea, Urinary Tra	ct infection, and Dementia.		for resident #6.	''	
	Medical record review	of the Nutritional	·			
	' Assessment dated Od Diet - Reg (reguler)	clober 16, 2013, revealed lactose freewt. (weight)		A new process has been put in p	lace	ı
	86 (pounds) IBW (Ide	al Body Weight)105"		on how Registered Dietitian noti	fies 🕛	
1				Director of Nursing, Assistant Director of Nursing, and/or		
1	Memo File Printout da	of the GeriMenu Resident		Registered Nurse Supervisor and	1	
	revealed " Weight on	10/10/13 86 0 Res		Administrator of Registered Dieti		1
	(resident) is 19 (pound food (and) fluids serve	is) (below)ibwintake of		recommendations. Nursing and	tian	ľ
	intake of food (and) flu	ids served"	.	dietary will review significant wei	ioht	1
1		i		changes and determine appropria	Sto	
	October 14, 2013, reve	of a laboratory report dated ealed "Total Protein		interventions within 7 days.	100	
	5.9Ref (reference) R 3.0Ref Ranges 3.4-5	anges6.4-8.2Albumin		The process share - to the		
- 1	_		ł	The process change includes the Registered Dietition providing		1
	Medical record review	of the Resident Weight		Registered Dietitian providing a coof all recommendations to the	ppy	
	Report dated October : resident's weight was {	23, 2013, revealed the	į	Director of Nursing, Assistant		
	_	•	ſ	Director of Nursing, Assistant Director of Nursing and/or		1
<u> </u>	Review of the ADL (Ac	tivities Daily Living)			- 1	

		A WIEDICAID SERVICES	_		OMD N	L. JI. LVOAET
STATEME AND PLAN	INT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL(A IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	D. 0938-039 ATÉ SURVEY MPLETED
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	F PROVIDER OR SUPPLIËR K Y PLACE AT KINGSP O	PRT		STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		0/23/2013
(X4) ID PREFIX TAG	/ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	NULD RE	COMPLETION DATE
	Verification Workshe through October 22, meal intake varied from the resident's room, sausage by the resident's family mer a good breakfast. Observation on October a good breakfast. Observation on October evealed the resident hamburger, all of the carrots. Interview on October with the Certified Diet conference room, revoletician (RD) was to below IBW with low pronfirmed the Register notified. Resident #6 was adm 30, 2013, with diagnose Pneumonia, Dysphagand Status Post Colose Medical record review August 31, 2013, reveolus ankle edema. Medical record review Assessment dated Seine resident was 5' 3" the resident received in the resid	set dated October 9, 2013, 2013, revealed the resident's om 50% to 100%. Sher 23, 2013, at 7:55 a.m. It seated in a wheelchair, in being fed eggs, oatmeal and lent's family member. The inher stated the resident eats her 23, 2013, at 1:00 p.m. ate approximately 3/4 strawberries, and a few 23, 2013, at 10:40 a.m., ary Manage, in the ealed the Registered be notified of residents rotein and albumin and red Dietician had not been dieted to the facility on August ses including Aspiration at Anemia, Hypertension, stomy. of the nursing notes dated aled the resident had four of a Nutritional ptember 3, 2013, revealed tall and weighed 117 lbs., sothing by mouth, received rna 1.2 at 55 ml (milliliters)	F 32	Registered Nurse Supervisor Administrator in addition to Certified Dietary Manager. Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor Administrator will review the recommendations and follow with the Certified Dietary Manager and nursing staff to ensure the physician is notified of recommendations timely. A new form used to record a feeding amounts and flush and by shift has been designed an placed on front of each Medi Administration Record for all patients receiving a tube feed educated by Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing and/or Registered Nurse Supervisor and Intake Output report on resident to ensure all nutritions status changes are addressed	the The The t and e v up anager he Il tube mounts nd cation ding ing. The and li ights each nal	

CENTERS FOR MEDICARI				OMB NO	3 NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	TE SURVEY MPLETED	
	445481		B. WING		10/23/2013		
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT				STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of periciencies Must be preceded by full SC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE	
	flushes of 50 mt, for Medical record revier note by the Register September 4, 2013, NPO (nothing by mo at 55 mt per hour by the tube feedings, we dema, the tube fee resident's needs and recommendations. Medical record revier September 25, 2013 from 117.3 jbs to 102 to increase TF (tube continuous. This wo 1872/24 hrs. Water stop wt loss." Medical record review weighed 95 lbs. on Commendation to imprehend at the physician had be recommendation to imprehend per hour until Octom Medical record review Note dated October (weight) loss noted be dramaticallyplan 1) and monitor resident. Medical record review Noted in the physician had be recommendation to imprehend noted by the dated October (weight) loss noted by the dated October 17, 200 Medical record review dated October 18, 200 Medical record review dated October 18, 200 Medical record review dated October 18, 200 Medical record review dated October 18, 200 Medical record review	ew of a High Risk Follow-Up and Dietician (RD) dated revealed the resident was both), received Gulcerna 1.2 feeding tube, was tolerating as admitted with some ding was meeting the I there were no new w of an RD note dated, revealed "wt (weight) loss 2.6 lbs 9/22/13Recommend feeding) rate to 65cc/hrutd increase catories to flush 100cc q 4 hrs. Goal = w revealed the resident actober 15, 2013. w revealed no documentation an notified of the increase the Glucerna to 65 ober 17, 2013. v of a Physician's Progress 17, 2013, revealed "wt. ut edema has improved (Increase) TF (tube feeding" v of a physician's order 13, revealed er extremities. Increase TF chr. (hour) if tolerate	F 37	The Certified Dietary Manag started care planning all diet changes. Weekly reviews of changes will be discussed in of Life/Quality of Care meeti Weight reports will be printing weekly and reviewed by Director of and/or Registered Nurse Surand Certified Dietary Manag. The results will be presented Director of Nursing to Qualit Assurance Process Improven committee monthly.	tary dietary Quality ings. ed ector of Nursing pervisor er.		

	OLIVIUS	TO CONTINUE OF THE	WINCHICAID SERVICES			MAR NO	2 2000	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		<u>91</u>
İ	445481		B. WING		į.			
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT					STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660	<u> </u>	0/23/2013	<u>.</u>
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EAGH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOUL)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	F 325	Continued From page 17 Observation on October 21, 2013, at 3:32 p.m., revealed the resident lying on the bed receiving Glucerna 1.2 at 65cc per hour.		F 32	25			7
	·	the Director of Nursin Office, confirmed the	22, 2013, at 2:45 p.m., with Ig (DON), in the DON's physician was not notified of to increase the Glucerna to clober 17, 2013.					
	10	Medical record review of tube feeding admin not documented.	v revealed the total amount histered to the resident was				<u> </u> 	
	v	evealed the resident	per 22, 2013, at 4:25 p.m., in the hallway, seated in a d observation revealed the iving tube feeding.			;		
	Te	evealed the resident I	er 23, 2013, at 9:40 a.m., receiving hair care in the nd was not receiving tube					
	ni re th	in Licensed Practica uraing station, (LPN resident #6), revealed to tube feeding as orce	23, 2013, at 10:00 a.m., I Nurse (LPN) #2, at the esponsible for the care of the resident did not receive fered by the physician for three and one-half hours at being out of bed.				·	
	re	ith the DON, in the Di sident's tube feeding cumented/monitored	3, 2013, at 10:10 a.m., ON's office, confirmed the Intake was not to ensure the resident te amount of tube feeding.					
_					<u></u>	- 1	i	i

CE	12-18-113 17:08 NTERS FOR MEDICAR	FROM-Asbury E & MEDICAID SERVICES	423			/0026 F-45
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
NAM	E OF PROVIDER OR SUPPLIE	445481	B. WING _		1	0/23/2013
ASE	URY PLACE AT KINGSF	ÖRT		STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		
PRE	FIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FILL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 60	OS) COMPLETION DATE
F 4	F 411 SS=D Facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services; must if necessary, assist the resident; and by arranging for transportation of the resident and by arranging for transportation of the resident in and could account for the resident's weight loss. F 411 SS=D SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.		F 411		ere ey or ons	11/30/2013

The findings included:

dentist.

reviewed.

bv:

residents with lost or damaged dentures to a

This REQUIREMENT is not met as evidenced

Based on medical record review, observation,

and interview, the facility failed to obtain dental

services for one (#8) of twenty-three residents

Resident #6 was admitted to the facility on August

and they will be asked if they have

dental pain as well as if they would

like to see a dentist. Arrangements will be made to transport to dentist

if resident wishes to see the dentist.

The mobile dental service will

All licensed nurses will be

by a Registered Nurse.

continue to visit every 6 months.

reeducated on mouth and dental

assessments by November 30, 2013

CENTE	.2-18-'13 17:08 F E RS FOR MEDICARE	ROM-Asbury & MEDICAID SERVICES	423	-245-8957	T-198		0026 F-45
		(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	<u> </u>	(X3) DA). 0938-039 TE SURVEY MPLETED
		445481	B. WING _			1	•
ASBUR	PROVIDER OR SUPPLIER Y PLACE AT KINGSPO	1		STREET ADDRESS, CITY, STATE 100 NETHERLAND LANE KINGSPORT, TN 37660	E, ZIP CODE	10	<u>/23/2013</u>
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOL THE APPRO	ii h ac	(X5) COMPLETION DATE
	Prieumonia, Dyspha and Status Post Collection form dated the resident did not he Medical record reviet Data Set dated Septe dental Issues were id Observation and interesident revealed the experiencing any toot Observation and interesident revealed the experiencing any toot Observation and interesident revealed the experiencing any toot Observation and interesident revealed the resident the revealed the r	oses including Aspiration gia, Anemia, Hypertension, ostomy. W of the Resident-Data of August 30, 2013, revealed have any teeth or dentures. W of the admission Minimum ember 12, 2013, revealed no entified. It wiew on October 21, 2013, if the resident lying on the her teeth, and stated needed ed interview with the resident was not he pain. View on Oct 22, 2013, at rector of Nursing (DON) lying on the bed, and the sident's teeth as signesting	F 411	A new more in-dept used to assess denta need for interventio Form will be comple admission and every Dental/oral assessmaudited by Director of Registered Nurse Sucharts per half per withen two per half momonths. Findings of the denta assessment audit will Quality Assurance Improcess monthly by Divising.	in health on by a detend upon six monerates will of Nursing pervisor. Bek for 4 onthly for all be reponsive means and the reponsive means and the reponsive means aroyemes.	and the entist. ths. be g, and/or Two weeks, 2	

Interview on October 22, 2013, at 3:05 p.m., with the DON, in the DON's office confirmed there had been no dental consultation arranged for the resident since admission.